Referral Forms

Utah's Department of Workforce Services Referral for Services Form. Employment counselors use the Referral for Services form to link clients with mental health and other services such as medical, housing, transportation, and legal services. Employment counselors send the forms to the Department of Workforce Services social worker assigned to the local welfare office. Social workers may also use this form to access mental health treatment for the client. The form takes approximately 10 to 15 minutes to complete.

Tennessee's Family Services Counseling (FSC) Referral Form. Tennessee's FSC Referral Form was developed exclusively for the FSC program. Employment case manager complete this two-page form to refer a client to the FSC program. The form includes basic demographic information, reason for referral, referral source, TABE test results, the employment case manager's name, and potential barriers to employment. The form takes between 20 and 25 minutes to complete.

Florida's TANF SAMH Program Certification (Referral) Form. Contracted service providers use this form to obtain authorization to provide mental health and substance abuse services to TANF recipients and other low-income families. Clients may be identified by outreach workers or referred directly to contracted service providers for mental health and substance abuse treatment. Contracted service providers complete this referral form and fax it to the TANF SAMH district specialist for approval. The form takes 10 to 15 minutes to complete.

Florida's TANF SAMH Services and One-Time Payment, Purchase of Service, Request/Approval Form. Florida's TANF SAMH specialists monitor and approve the services provided through the contracted TANF SAMH treatment agencies. Every six months, a TANF SAMH specialist reviews each case. These specialists are given wide latitude in deciding which services should be provided and for how long.

DWS EDD
FORM 360, 399

Department of Workforce Services
REFERRAL FOR SERVICES

Date: _____

Customer's Name: _____ SSN: _____

Address: _____ Zip Code: _____

Phone: _____ Alternate: _____ Household Size: Adult(s): _____ Children: _____

REFERRED TO: _____
Agency Address City Zip

Contact Person: _____ Phone: _____ Ext: _____

REFERRED FOR:

☐ Assessment	☐ Emergency Aid	☐ Transportation
☐ Family Services	☐ Medical Services	☐ Food Assistance
☐ Educational Information	☐ Financial Assistance	☐ H.E.A.T.
☐ Counseling, Personal	☐ Housing	☐ Legal Services
☐ Veteran's Services	☐ Abuse Advocate	☐ Other

Specify: _____

REFERRING EMPLOYMENT CENTER: _____
Office Address City Zip

Referred by: _____ Phone: _____ Fax: _____

Results requested: ☐ Yes ☐ No Comments: _____

☐ Release of Information attached

ATTACHMENTS (if applicable):

☐ Assessments	☐ Intake\Eligibility	☐ Employment Plan
☐ Medical Records	☐ Payment Authorization	☐ Other: _____

Note to the Customer: "THIS IS A REFERRAL ONLY!" Services will be determined by the provider according to agency guidelines.

FAMILIES FIRST
Creating Opportunities for Families

Family Services Counseling Referral Form

☐ EMERGENCY REFERRAL
Referred by: _____
Signature: _____
☐ SELF REFERRAL

SECTION I - TO BE COMPLETED BY THE TDHS COUNTY OFFICE

(Please complete all questions in this section before giving the referral to the Family Services Counselor)

1. Date ____ / ____ / ____
   mm dd yy
2. Customer Name: _____
   (Last) (First) (MI)
3. Customer Case/Cat/Seq #: _____ / ADC___ / _____
4. County: _____
5. Families First Status (please circle appropriate status)
   1 Active - If active: _____# of mos. used in current 18-mo. period _____# of mos. in 60-mo. count
   2 Transitional - Effective Date of Closure ____ / ____ / ____
   mm dd yy
6. Recipient ID#: _____
7. Social Security #: _____-_____-_____
8. Date of Birth _____/_____/_____
   mm dd yy
9. Dates of any PRIOR referrals to Family Services Counseling:

_____ None (please check if none)

Date (mm/dd/yy)	County	Was Family Services Counseling provided? (check one column) Yes	No

10. Current Referral Type (check ALL that apply):
(please check the number(s) from the main categories that describes the referral type. If the customer is in category 3, please check the sub categories which apply)

___ 1. Individual currently has FSC on the PRP and is reentering FSC to come into compliance. No time limit interruption is needed.
___ 2. Individual is non-compliant with PRP.
___ 3. Individual is compliant, has work requirement and/or ABE and (please check all that apply):

- ___ a. exhibits signs of obstacles as noted by caseworker
- ___ b. has been identified by a service provider as having obstacles
- ___ c. frequently requests renegotiations of PRP
- ___ d. children in the assistance group have behavioral problems
- ___ e. relatives of the customer have health problems that cause difficulty in compliance
- ___ f. other, please specify: _____

___ 4. The individual has a work requirement and is requesting a referral.
___ 5. Participant is in self-initiated treatment or domestic violence program.
___ 6. Customer is in transitional status and is requesting a referral.
___ 7. Eligible adult is exempt from work requirement, but is requesting a referral.

11. Who identified the need for the referral? (check all that apply and provide additional information where necessary)

____ 1. Caseworker

____ 2. Service provider (name/component) _____

____ 3. Post employment specialist (name) _____

____ 4. Dept. of Health Professional (name) _____

____ 5. Self referral

____ 6. Other (please specify) _____

12. TABE Results

_____ 1. TABE Result _____ Result Date ____ / ____ / ____
mm dd yy

_____ 2. Customer has not taken the TABE

13. Caseworker's name (PRINT): _____

14. Caseworker's signature: _____

15. Mandatory Attachments: ____AEICI ____IQAM ____AEIAS ____AEITI ____ AEIPA (current and prior to adding FSC Assessment)

(please check all attached documents)

____ AEIHH (referred individual must be target individual on screen)
____ AEIWE (if applicable)
____ AEIEI (if applicable)

16. DO NOT ASK --- *IF* known to you, please check possible barriers (check ALL that apply)

____ 1. Domestic violence
____ 2. Mental health
____ 3. Substance abuse
____ 4. Learning disabilities
____ 5. Child(ren)'s health or behavior problems
____ 6. Other _____
____ 7. Unknown

17. Caseworker Comments: _____

_____

_____

_____

SECTION II - TO BE COMPLETED BY THE FAMILY SERVICES COUNSELOR

18. Family Services Counselor's Name: _____

19. Date referral received by Counselor: ____ / ____ / ____
mm dd yy

Confidential & Privileged Information; CFR 42, Part 2 regulations apply

TANF SAMH Program Certification Form

Agency Name: _____ Phone:_____ Date: _____

On behalf of the agency listed above, I certify, all available information given to be true and correct.

Authorizing Staff: (print) _____ (signature): _____

TANF SAMH Participant Information

Name: _____ SSN: ____-____-____ DOB: ____-____-____

Address: _____ Phone: _____

If Participant is a child, is he/she in the care of someone other than his/her parent? ☐ No ☐ Yes

How Long? _____ What is the relationship of the caregiver to the child? _____

Child's Name: _____ SSN: ____-____-____ DOB: ____-____-____

Total Household members: #Dependent Child(ren) in the home: _____ # Adults in the home: _____

Clinical referral focus for: ☐ Substance Abuse ☐ Mental Health ☐ Dual Diagnosis

Is participant currently in treatment? ☐ Yes ☐ No Admission Date: _____

TANF SAMH Eligibility Population & Criteria for Certification

Check the eligibility for TANF treatment for which you are basing your referral for either a Temporary Cash Assistance (TCA) participant or TANF SAMH Diversion Family(TDF). EACH BOX under one population must be checked in order for the referral to be accepted.

Temporary Cash Assistance (TCA)

☐ **Participant type** (*circle one*)
- a. Applicant/recipient
- b. Family member
- c. Post-TANF
- d. Child-only case

☐ **Employment and family instability due to MH/SA problems**

☐ **Not a SSI recipient**

TANF SAMH Diversion Family (TDF)

☐ **Eligible Family includes** (*circle one*)
- a. Parent(s)/Relative Caretaker with on or more minor children living in the home
- b. Pregnant woman
- c. Family Safety involvement with TX on active reunification plan or in temporary Shelter Care
- d. Non-custodial parent with child support court order
- e. SSI / SSDI family with work directive goals

☐ **Family at risk of becoming welfare dependent due to MH/SA problems**

☐ **Family annual income of $_____ meets the 200% below federal poverty level**

TANF SAMH Eligibility Certification

Based on the FLORIDA System for TCA participants or information provided by the SAMH agency for the TANF diversion families, I certify that this participant is / is not eligible for TANF services in the checked population:

☐ **TCA (cash)** ☐ **TDF (diversion)** ☐ **Ineligible***(reason)* _____

TANF SAMH Specialist's Signature: _____

Certification Number (if applicable): _____ Date of Certification: _____

TANF SAMH SERVICES & ONE-TIME PAYMENT
Purchase of Service
Request / Approval Form

Agency: _____ Case Manager: _____ Date: _____

Section A: Request for Service Funding Authorization (usually completed by the case manager)

1. TANF Participant name or number: _____ 2. SS#: _____

3. DOB: _____ 4. Race: _____ 5. Sex: M or F 6. Yearly Income: _____

7. Description of Goods/Services requested: _____

_____

_____

8. General reason for request/benefit to participant: _____

_____

_____

_____

9. Alternatives explored: _____

_____

_____

10. Funding amount requested: $_____ 11. Vendor (Name, Address, and Vendor ID#) _____

_____

_____ _____

Case Manager Signature / Date *Case Manager Supervisor's Signature*

Section B: Action Taken

Letter of Approval Sent / Date: _____ Date Funds Encumbered: _____

Letter of Disapproval Sent / Date: _____ Reason for Disapproval / Instructions: _____

_____

_____

_____ _____ _____ _____

TANF SAMH Specialist Signature / Date *Approved* *Disapproved* *SAMH Auth. #*